STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44261 Olympia, Washington 98504-4261

BILLING INSTRUCTIONS – STATE FUND CLAIMS
STATEMENT FOR MISCELLANEOUS SERVICES BILL FORM
F245-072-000

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Advanced Registered Nurse Practitioner,
Certified Registered Nurse Practitioner, Registered Nurse,
Dental Services, Durable Medical Equipment,
Drug & Alcohol Treatment, Licensed Massage Therapy,
Nurse Case Management, Obesity Treatment,
Occupational Therapy, Optometry/Optician Services,
Vocational Rehabilitation Services

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BILLING INSTRUCTIONS

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

L&I Provider Account Number Required:
If you do not have an L&I provider account number, please call Provider Accounts at (360) 902-5140 to request a provider application form. This form and several other of the most frequently requested forms can also be downloaded from our website at www.wa.gov/lni/forms. You may also request additional forms from your local field service location; a listing of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

Billing on Paper Forms:
Submit charges on the Department's "Statement for Miscellaneous Services" bill form (F245-072-000).

Mail "Statement for Miscellaneous Services" bill forms to:

Department of Labor and Industries
PO Box 44267
Olympia, Washington 98504-4267

Bill Forms – Where and How to get them:
Bills must be submitted on ORIGINAL (not photocopied) Statement for Miscellaneous Services bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at (360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000 for single sheet, or FXXX-XXX-111 for continuous pinfeed).

Billing Electronically:
Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

When to Submit Bills:
You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

When payments are made:
The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.** Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries
Cashier's Office
PO Box 44835
Olympia WA 98504-4835

Limits on Bill Processing:
Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

For Help:
If you have questions about "PAID BILLS", "DENIED BILLS" or "ADJUSTMENT BILLS", please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.**

If you have questions about "BILLS IN PROCESS", please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the "zero" option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any 'wait time' is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.

PROVIDER SPECIFIC INSTRUCTIONS

Advanced Registered Nurse Practitioner
Certified Registered Nurse Practitioner
Registered Nurse

Type of Service:

Use Type of Service code "N"

Advanced Registered Nurse Practitioner

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245.
ARNP services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician.

Certified Registered Nurse Anesthetists
Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245. CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are -QX and -QZ.

Please also refer to the "Anesthesia Payment Policies" section of the current fee schedule.

Registered Nurse as Surgical Assistants
Licensed registered nurses may perform surgical assistant services if the registered nurse submits all of the following documents to the department or Self-Insurer:

- A photocopy of her or his valid and current registered nurse license, and
- A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is **ninety** percent (90%) of the allowed fee that would otherwise be paid to an assistant surgeon (physician).

For further information please refer to WAC 296-23-240 & WAC 296-23-245

Dental Services

Type of Service:

Use Type of Service code "4" if billing Level II HCPCS code(s). These codes begin with the letter "D", followed by 4 numbers (e.g., D0120). See the HCPCS section in the current fee schedule for a listing of codes.

Use Type of Service code "3" if billing Level I CPT code(s). These codes consist of 5 numbers (e.g., 99201). See the Medicine section in the current fee schedule for a listing of codes.

Copies of the HCPCS Level I and II codes may be purchased from:

The Superintendent of Documents
United States Government Printing Office
Washington DC 20402

DME & Other Services

(Includes Hearing Aid Fitter/Dispensers, Audiologists, Interpreters, Ambulance, Public Transportation)

Type of Service:

Use Type of Service code "9" on the Statement for Miscellaneous Services form when billing for durable medical equipment or any of the above services listed.

Modifier Codes:

Use modifier code "RR" for rental items.
Use modifier code "RP" for replacement and repair.

Pharmacies and durable medical equipment providers may bill for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax, and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill, but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

TENS units (Transcutaneous Electrical Nerve Stimulators) and supplies are paid under special contract only. Refer to the section on "Transcutaneous Electrical Nerve Stimulators (TENS)" in the current fee schedule under "Specialty and Administrative Services" section.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

Drug & Alcohol Treatment

Type of Service:

Use Type of Service code "9" and the Local codes listed later in this section when billing for drug and alcohol rehabilitation services.

Use Type of Service code "3" and standard CPT codes when billing for laboratory procedures.

WAC 296-23-185 Drug and alcohol rehabilitation services. Authorization requirements for these services may be found in WAC 296-20-03001 and 296-20-055. Please refer to the provider bulletin listing in the current fee schedule for any information updates. If you would like to obtain a copy of the most current provider bulletin, please call the Health Service Analysis section at (360) 902-6799.

0141M	Intake Evaluation
0142M	Physical Examination
0143M	Individual Therapy, Routine Visit
0144M	Individual Therapy, Brief Visit
0145M	Group Therapy
0146M	Chemotherapy
0147M	Medication Adjustment
0149M	Detoxification facility (room & board)

Licensed Massage Therapy

Type of Service:

Use Type of Service code "9" and procedure code 97124 when billing for Massage Therapy Services.

Note: DO NOT bill services spanning multiple dates. Bill one date per line.

Massage therapists are allowed to bill only one CPT code for massage (97124). 97124 is a timed code with a 15 minute value. Massage therapists should bill their usual and customary fee and designate the duration of the massage therapy treatment by the number of units in the 'UNIT' field.

Units are measured as follows:
1 unit = 15 minutes
2 units = 30 minutes
3 units = 45 minutes
4 units = 1 hour

The department will not reimburse massage therapists for additional costs that are not specifically allowed. Application of hot and cold packs, anti-friction devices and lubricants (e.g., oils, lotions, emollients, etc.) are bundled, and are not payable separately.

"No inpatient massage therapy treatment will be allowed when such treatment constitutes the only or major treatment received by the worker. See WAC 296-20-030 for further information."

Refer to WAC 296-23 for additional information.

Authorization Required:
"Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker's attending doctor." (WAC 296-23-250)

"Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the department or self-insurer." (WAC 296-23-250)

"Massage therapy treatments exceeding once per day must be justified by attending doctor." (WAC 296-23-250)

Please refer to WAC 296-23-250 for additional information and reporting requirements.

Nurse Case Management

Type of Service:

Use Type of Service "9" with Local codes 1220M – 1225M when billing for Nurse Case Management Service.

All nurse case management services require prior authorization. Please refer to PB 98-01 for Payment Policy for Nurse Case Management Services. To request a copy of the current provider bulletin, please call (360) 902-6799 or can be viewed/downloaded from www.wa.gov/lni/hsa/hsa_pbs.htm.

Nurse case management services are capped at 50 hours of service including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases contingent upon review by the insurer.

CASE NOTE INSTRUCTIONS

A case record will be created and maintained on each claim. The case record shall present a chronological history of the injured worker's progress in Medical Case Management services. A case manager's services can be denied or reduced if the required documentation is not provided in the case notes or if the service does not match the procedure code billed.

Case notes shall be written when a service is given and shall specify:
1) When a service was provided,
2) What type of service was provided, using case note codes (See Attachment A),
3) A description of the service provided including person(s) involved, outcome, and future plan, if applicable and
4) How much time was used.

Copies of reports, correspondence, and expenses shall be maintained in the case record.

Case note codes will be used to document the type of services provided to or on behalf of the injured worker. Case note codes, including case note documentation requirements are explained fully in Attachment A. The table below describes the case note and billing codes. New maximum allowable fees are also noted.

CASE NOTE CODES	BILLING CODES
PCW, PCD, PCE, PCV, PCP, and PCO	1220M – Phone Calls Per Unit
VW, VD, VE, VV, VP, and VO	1221M – Visits Per Unit
CR, FRV, COR, RE, RW, RR, and TC	1222M – Case Planning Per Unit
TR, WA	1223M – Travel/Wait Per Unit
N/A	1224M – Mileage per mile
N/A	1225M – Expenses at Cost (includes parking, ferry, cab, toll fees, lodging and airfare)

* - 1 unit equals 6 minutes of time. Per unit amounts are multiplied by 10 to equal the rate per hour.

Case note codes shall be converted to billing codes as bills are processed by the nurse case manager or firm. For example, all time associated with telephone calls during a 30-day period is added, converted

to units of service and then total charges. Likewise, all time associated with visits during a 30-day period is added, converted to units of service and then total charges, etc. Examples below describe how to convert time to units and calculate total charges. Examples are also shown for mileage and expenses.

Phone Calls, Visits or Case Planning:

Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units 102 minutes/6 = 17 units

Step 2 – Units of Total Charges

Total units time per unit charge = Total charges 17 units x $8.09 = $137.53

Travel / Wait:

Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units 150 minutes/6 = 25 units

Step 2 – Units to Total Charges

Total units times per unit charge = Total charges 25 units x $3.98 = $99.50

Mileage:

Mileage is reimbursed at the Washington State rate for mileage reimbursement. The current amount is $.35 per mile. Mileage during a 30-day period is added then multiplied by .35 to obtain the total mileage expenses for the month. For example:

112 miles x .35 = $39.20

Expenses:

Expenses will be reimbursed at cost. Receipts for expenses shall be maintained in the case record. Receipts for parking are not required, but preferred. All expenses with a 30-day period shall be added, then coded as 1225M on the Statement for Miscellaneous Services bill form.
Attachment B describes covered and non-covered medical case management expenses.
An example follows:

$5.00 (parking) + $7.50 (records) = $12.50

ATTACHMENT A
CASE NOTE CODES

Phone Calls

PCW:	Injured worker, family members, injured workers' attorney or legal representative.
PCD:	Department of Labor and Industries staff.
PCE:	Employer or employer representatives.
PCV:	Vocational rehabilitation counselors.
PCP:	Attending physician, physician consultants, and other allied healthcare personnel.
PCO:	Governmental agencies, social services, community and/or volunteer resources, etc.

Visits

VW:	Injured worker, family members, injured workers' attorney or legal representative.
VD:	Department of Labor and Industries staff.
VE:	Employer or employer representative
VP:	Attending physician, physician consultants, and other allied healthcare personnel.
VO:	Governmental agencies, social services, community and/or volunteer resources, etc.

Case Planning

CR:	Case Review: review and analyze current or new data between monthly reporting periods.
FRV:	File Record Review: review and analyze historical file documentation.
COR:	Correspondence: prepare correspondence, i.e., letters memo, fax.
RE:	Research: research medical literature, condition specific.
RW:	Report Writing: prepare monthly reports, i.e., initial, progress and closure reports and special reports.
RR:	Record Retrieval: obtain medical records, reports or evaluations.
TC:	Team Conference: participate in or conduct team conferences.

Travel / Wait

TR:	Travel: travel to person being visited
WA:	Wait to meet with person(s) being visited.

Mileage **Not applicable**.

Expenses **Not applicable**.

CASE NOTE CODES, DESCRIPTIONS AND INSTRUCTIONS

PHONE CALLS

Definition: made by or to a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instructions; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to facilitate the worker's recovery; to assess the success of current therapies or treatment, overall.

Billing Instructions: Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the call, to whom the phone call was made, their title if applicable (MD, RN, DO, PT, etc.), the reason for the call, details of the discussion and length of phone call.

Billing coded and Descriptions:

PCW:	Includes phone calls to injured worker, family members, injured worker's attorney or legal representatives.
PCD:	Includes phone calls to Department of Labor and Industries claims managers, occupational nursing consultants, supervisors, and other department staff.
PCE:	Includes phone calls to employer or employer representatives to access information or facilitate return to work for the injured worker.
PCV:	Includes phone calls to vocational rehabilitation counselors for coordination of rehabilitation services.
PCP:	Includes calls to attending physician, physician consultants, and other allied health care personnel to facilitate health care service delivery.
PCO:	Includes phone calls to other governmental agencies, social services, community and/or volunteer resources to provide for the injured worker's health care needs.

VISITS

Definition: Onsite meetings or scheduled face-to-face meetings by a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instruction; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to further recovery; to assess the success of current therapies or treatment overall when telephonic services are not adequate to obtain the necessary information.

Billing Instructions: Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the visit, who was visited, their title if applicable (MD, RN, DO, PT, etc.), the reason for the visit, details discussed and the length of visit.

Billing Codes and Descriptions:

VW:	Includes visits with injured worker, family members, injured workers' attorney or legal representative.
VD:	Includes visits with the Department of Labor and Industries claims managers, occupational nursing consultants, supervisors, and other department staff.
VE:	Includes visits to employer or employer representatives to access information or facilitate return to work for the injured worker.
VV:	Includes visits with vocational rehabilitation counselors for coordination of rehabilitation services.
VP:	Visits with the attending physician consultants, and other allied health care personnel to facilitate health care service delivery.
VO:	Visits with other governmental agencies, social services, community and/or volunteer resources to provide for the injured worker's health care needs.

CASE PLANNING

1) Case Review (CR)

Definition / Billing Instructions: The time taken to review and analyze current or new data between monthly reporting periods; includes documentation of impact of new data on overall case plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date, case note with the data and description of the data, analysis, and plan. Case planning is not to be billed for writing case notes to document onsite visits or phone calls. Phone calls and visits already include payment for associated documentation.

2) File Record Review (FRV)

Definition / Billing Instructions: The time taken to review and analyze historical file documentation at the onset of referral to medical case management. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing the date of review, material reviewed, and time spent reviewing the records. If a separate file review is completed, a copy of the document will be kept in the working file and attached to the monthly report. Copies of historical file documents shall be kept with the nurse case manager's case record.

3) Correspondence (COR)

Definition / Billing Instructions: The time taken to prepare correspondence, i.e., letters, memo, fax to the department, injured worker, provider, vocational counselor and other governmental agencies, social services, community and/or volunteer resources for the purpose of updating,

clarifying or confirming the medical treatment plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date when the correspondence was produced, a case note describing the correspondence and time to prepare the correspondence. A copy of the document will be kept in the case record and attached to the monthly report.

4) Research (RE)

Definition / Billing Instructions: The time taken to research medical literature, condition specific. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date research was conducted, a summary of the findings of the literature review, the impact of the information on the injured worker's case plan, and time to complete research. If document produced, a copy will be kept in the case record and attach to the monthly report.

5) Report Writing (RW)

Definition / Billing Instructions: The time taken to prepare monthly reports, i.e., initial, progress and closure reports, as well as special reports requested by department representatives. Bill 1 unit of service for each 6 minutes of time. The initial report shall not exceed 2 billable hours per case. Progress and closure reports shall not exceed 1 hour per case.

Documentation of this service is to include the date of the report, a notation in the case notes, a report, (for special reports, note requesting part in case note documentation using appropriate billing code, e.g., PCD or VD) and the time to complete the report. A copy of the report will be kept in the case record and sent to the claims representative on a monthly basis.

6) Record Retrieval (RR)

Definition / Billing Instructions: The time taken to obtain records, reports or evaluations not currently contained in the department's records for case planning. This method of obtaining records should be limited. The most cost-effective method of obtaining records should be used first, prior to use of professional time, e.g., faxing, mailing, etc. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date of record retrieval, a case note identifying the record source, summary of records obtained, and the total time (including travel, wait, and photocopying cost) to obtain the report.

7) Team Conference (TC)

Definition / Billing Instructions: The time taken to participate in or conduct a team conference with 3 or more health care professionals, vocational rehabilitation counselors, employer, injured worker and/or representative, or other governmental agencies, social services, community and/or volunteer resources to coordinate activities of patient care, provide for the injured worker's health care needs and/or return to work efforts for the injured worker. Includes documentation of

impact of conference data on the overall case plan. Bill 1 unit of service for each 6 minutes of time. Visit codes are not to be billed for team conferences.

Documentation of this service is to include the date of the conference, a case note, summary of conference findings, analysis, plan of action, and time.

TRAVEL (TR)

Definition / Billing Instructions: The time to travel from the nurse case manager's home office or home, whichever is closest, to the person being visited. Bill 1 unit of service for each 6 minutes of time. Transportation costs including parking, ferry, toll fees, cab, and airfare are reimbursable at cost. Travel expenses resulting from single or multiple visits which involve visits or conferences on more than one injured worker must be prorated between the multiple injured workers visited. For example, if the case manager travels to a hospital in Seattle, and visits with 3 injured workers, the costs should be billed by dividing the mileage and travel time between the three cases.

Documentation of the service is to include date of travel, a case note with starting and ending location, whether visit was prorated, mileage, odometer reading start and finish, and other associated transportation expenses, and time.

Mileage costs may be reimbursed at $.35 per mile or the current Washington state rate for mileage reimbursement. Mileage costs should be billed using the 1224M mileage billing code. Parking, toll, ferry, cab or airfare expenses will be billed with the new 1225M expense billing code. Meals and lodging required outside normal business hours will be paid with prior approval by the claims manager and at the state per diem rate in effect at the time for the area. Meals and lodging and a copy of any original invoice shall be kept in the case record for a minimum of five years.

WAIT (WA)

Definition / Billing Instructions: The time to wait to meet with person(s) being visited during scheduled visits. Bill 1 unit of service for each 6 minutes of time to a maximum of 2 hours. Case managers are encouraged to use wait time to conduct other business e.g., phone calls, visits, case planning, file record review, and record retrieval during wait time.

Documentation of the service is to include the date of wait time, a case note with location of visit, time of arrival at appointment, and end time (when appointment visit began).

ATTACHMENT B

COVERED AND NON-COVERED EXPENSES

COVERED EXPENSES:

The following expenses will be covered –

- Transportation other than mileage, including parking, ferry, toll fees, and cab. Mileage is reimbursed at $.35 per mile or the current Washington state rate for mileage reimbursement.
- Meals and lodging required outside normal business hours with prior claims manager approval and at the Washington state per diem rate in effect at the time for the area.
- Airfare with prior approval from the claim manager.
- Mileage greater than 150 miles round trip requires prior approval from the claims manager.
- Fees for obtaining medical records, reports or evaluations per request of department and at no more than the maximum allowable rate of .35 per page.

NON-COVERED EXPENSES:

The following expenses will not be covered –

- Activities associated with nurse case manager training, e.g., training on office policies and procedures, including report writing and billing.
- Supervisory activity such as supervisor – nurse case manager visits, case reviews or conferences between supervisor and nurse case manager.
- Postage, printing or photocopying costs (with the exception of medical records per request of department). See above explanation.
- Telephone expenses including unanswered phone calls, long-distance phone calls, and facsimile.
- Time spent on any clerical activity, including processing a referral, file "set up", typing, copying, mailing, distributing, filing, invoice preparation, record keeping, delivering or picking up mail.
- Travel time to a post office or a fax machine.
- Wait time exceeding 2 hours.
- Fees related to legal work, e.g., deposition, testimony, etc. Legal fees may be charged to the requesting party, but not the claim. Contact the requesting party regarding how legal services are billed.
- Any other administrative cost not specifically mentioned above.

Obesity
Occupational Thpy

Obesity Treatment

Type of Service:

Use Type of Service code "9" and the Local codes listed below.

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. Refer to Provider Bulletin 97-03 for more information.

The attending doctor may request a consultation with a certified dietician or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker.

The procedure codes for obesity treatment are as follows:

1030M	Intake Dietary Evaluation
1034M	Dietary Reevaluation

Occupational Therapy

Type of Service:

Use Type of Service code "9" for HCPCS codes
Use Type of Service code "3" for CPT codes

*** **After 12 treatments, you must get new orders from the attending physician and authorization from the claims manager**

REPORTING REQUIREMENTS

NOTE: CURRENTLY THERE ARE NO PROVISIONS TO PAY OCCUPATIONAL THERAPISTS SEPARATELY FOR REPORTS

***** DO NOT ATTACH REPORTS TO THE BILLS*****

Send all reports (correspondence) for State Fund claims to:

Department of Labor & Industries
PO Box 44291
Olympia WA 98504-4291

A. Consultation reports
B. Laboratory and X-ray reports
C. Special reports and/or narratives to support level of office visit or procedure
D. Operative reports/anesthesia records

E. Periodic office notes
F. Periodic chart notes

Occup.Thpy con't.
Optometry/Optician
Voc Rehab Svcs

The injured workers' name and claim number must be placed in the upper right corner of each page on any correspondence or report.

The cost invoices for supplies furnished are not routinely required, but may be requested by the department in specific cases.

See WAC 296-20 for additional requirements and report definitions.

Optometry/Optician Services

Type of Service:

Use Type of Service code "9" for HCPCS codes
Use Type of Service code "3" for CPT codes

Please refer to WAC 296-20-100 Eye glasses and refractions for more information.

Vocational Rehabilitation Services

Type of Service:

Use Type of Service code "V" for Vocational codes

This section details the requirements and information Vocational Rehabilitation providers should know and follow in submitting bills.

How to Submit a Bill

Each provider who works on a referral must bill separately and must list the precise number of units of service worked for each date span on a referral. Each date span billed must have both a start and end date. The provider must also bill for each referral separately. Even if a third party does the billing, the provider receiving the referral is responsible for ensuring that all billing is correct.

In cases where more than one provider delivers services on a referral (e.g., where interns assist on referrals assigned to a VRC, or where one VRC covers for another VRC who is ill), each provider must bill separately for services delivered on the referral. Each provider must use his or her individual provider number, as well as the payee provider number and the referral Identification Number (see section below). The department will reject and not pay bills missing this information. It is important that providers understand that the payee provider identification number of all other providers working on a referral must be the same as the assigned Vocational Rehabilitation Counselor's, or the department will not pay the bill.

Example: Acme Rehabilitation employs counselor X, as well as interns Y and Z. Acme may not submit aggregate bills: Acme Rehabilitation must submit a separate bill for Counselor X, Intern Y, and Intern Z—for each referral worked by X, Y, and Z.

For more detailed information about completing billing forms, consult the samples of completed forms, which are located in an attached section.

Reimbursement Rates

The department has established separate reimbursement rates for different provider specialties. The department will reimburse interns at 85% of the VRC professional rate: forensic evaluators will receive 120% of the VRC professional rate.

The table below lists the professional, travel/wait, and mileage rates for vocational services:

Provider Type	Rate
VRC Professional Rate	$73/hour
Intern Professional Rate	$62/hour
Forensic Rate	$88/hour
Travel/wait Rate	$36.50/hour
Mileage Rate	Current State Rate/mile

Fee Caps and Thresholds

As part of the changes to the reimbursement structure, the department has adopted fee caps. Providers must be aware that fee caps are ***hard*** caps, with ***no*** exceptions.

At 100 percent of the fee cap, the claim manager can either act directly or request that the Vocational Services Consultant conduct a review of the case. The claim manager may re-refer the case to another Vocational Rehabilitation Counselor or make another appropriate decision, based on the circumstances of the claim, such as the following: making a referral to pension, making a forensic referral, or closing the referral for medical instability reasons.

In situations where the case reaches the fee cap and the department decides another referral is warranted, the case must be started as quickly as possible (within two to three days). ***Vocational Rehabilitation Counselors must therefore submit closing reports promptly.***

When cumulative payments for a referral have reached the cap, the Remittance Advice sent with the payment will contain an Explanation of Benefits, indicating that the referral has reached its fee cap. The department will adjust the amount of the bill to pay ***no more*** than the fee cap allows and will authorize ***no*** payment beyond the cap. It is very important that vocational providers work closely with their billing staffs to monitor costs on their referrals.

Please consult the following fee cap table:

Code	Fee Cap	Equiv. VRC Hours[1]	Comments
0800V 0801V	$1,500 combined	20.5 hours	
0810V 0811V	$2,500 combined	34.2 hours	
0821V 0823V 0824V	$1,100		
0830V 0831V	$5,000 combined	68.5 hours	
0840V 0841V	$4,725 combined	64.7 hours	
0881V 0882V 0883V 0884V			
0891V 0892V 0893V 0894V 0895V			Pre-authorization by CM required

Codes

The following table lists the codes, and their corresponding definitions, for use in billing for vocational services. Reimbursement will occur according to the level of provider described below. Separate codes and provider specialties exist for vocational interns, counselors, and forensic examiners.

Example: Intern Y at Acme Rehabilitation bills code 0881V. Result: The department does not pay, because it only authorizes qualified providers to do forensic work.

Code	Description	Counselor Level
	EARLY INTERVENTION	
0800V	Early Intervention Services	VRC
0801V	Early Intervention Services—Intern	Intern

[1] Based on $73/hour for professional VRC services.

	ASSESSMENT	
0810V	Assessment Services	VRC
0811V	Assessment Services—Intern	Intern

	VOCATIONAL EVALUATION	
0821V	Work Evaluation	VRC
0823V	Pre-job or Job Modification Consultation	VRC
0824V	Pre-job or Job Modification Consultation—Intern	Intern

	PLAN DEVELOPMENT	
0830V	Plan Development Services	VRC
0831V	Plan Development Services—Intern	Intern

	PLAN IMPLEMENTATION	
0840V	Plan Implementation Services	VRC
0841V	Plan Implementation Services—Intern	Intern

	FORENSIC AND TESTIMONY	
0881V	Forensic Services	VRC—Forensic
0882V	Testimony on VRC's Own Work	VRC
0883V	Testimony on Intern's Own Work	Intern
0884V	AGO Witness Testimony	VRC

	OTHER	
0891V	Travel/Wait Time	VRC
0892V	Travel/Wait Time—Intern	Intern
0893V	Professional Mileage	VRC
0894V	Professional Mileage—Intern	Intern
0895V	Air Travel	Intern/VRC/ VRC—Forensic

New Codes

The department has developed five new codes for use by vocational providers and other providers delivering services related to a vocational referral. The codes will be effective for dates of service beginning June 1, 2001. The codes will be payable, (i.e., they will become active in the department's bill payment system) beginning September 24, 2001. Bills submitted prior to this date with the codes will not pay and will have to be resubmitted.

The codes are:

Code & Description	Early Int.	Assess.	Plan Dev.	Plan Imp.	Forensic	Provider Type(s)
0896V – Ferry Charges	M	M	M	M	M	68
0897V – Hotel Charges *	O	O	O	O	O	68

0391R – Travel/wait (non–voc)	O	O	O	O	O	34, 52, 55, 97
0392R – Mileage (non-voc)	O	O	O	O	O	34, 52, 55, 97
0393R – Ferry Charges (non-voc)	O	O	O	O	O	34, 52, 55, 97

* This code is only allowable for approved out of state cases.
M – code loads automatically when referral is made
O – claim manager must load code after specific authorization

Codes 0896V, 0897V, and 0393R are payable By Report, and a receipt must be placed in the case file for documentation. Code 0391R pays at $4.05 per unit. Recall that the department requires billing for services in units, in increments of 6 minutes per unit, or 10 units per hour. Code 0392R pays at the standard federal rate per mile, similar to codes 0893V and 0894V.

Ancillary Services Reminder…

As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider number than you), you cannot bill as a vocational provider (a provider type 68). You must either use another provider number that is authorized to bill the ancillary services codes (type 34, 52, 55) or obtain a miscellaneous services provider number (type 97) and bill the appropriate codes for those services.

Date Span Information

When providers are completing billing forms, it is very important to include both start and end dates for the date span of services. Providers must include all services provided during this date span on the bill. They may not submit a new bill for additional services during the same date span. If this circumstance occurs, a "Provider's Request for Adjustment " form must be completed to adjust the original charges.

Units of Service

One unit of service equals 6 minutes of time. The stated hourly rate is equal to 10 units of service. The unit of service for mileage reimbursement is per one mile.

Example: the professional VRC rate is $73 per hour; 1unit of service (6 minutes) pays $7.30 ($73.00/10); 2 units of service (12 minutes) pays 2 x $7.30 = $14.60

Referral Identification Number on Bills

When completing billing forms, a provider must include the referral identification numbers for each submitted bill. The department will deny payment for any bill submitted without a referral identification number. Each department referral has a unique referral identification number.

Documentation

Documentation that supports billing includes the provider's case notes. Providers should ensure that their case notes include evidence of the time spent on various activities. **Example:** A provider who spends a half-hour on a progress report for a case might specify that half-hour in his or her case notes as ".5 hours preparing progress report."

Travel/Wait and Mileage

The department developed separate codes for vocational providers' travel/wait time. The department pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The department does NOT pay for travel time between two different service locations or branch offices where a provider is working cases.

Providers should bill from the branch office where the referral has been received by the VRC to necessary destinations, such as the following: going to the location of the employer of record, visiting an attending physician's office, and the meeting of a VRC with an injured worker at his or her home.

Example: A vocational counselor indicates to the department that he or she is willing to work referrals in Seattle, Yakima, and Longview.
Result: The department will reimburse the provider for travel/wait time on cases in each of these three areas, but will not pay for the provider to drive from Seattle to Yakima, or from Longview to work a Seattle or Yakima referral.

Travel/wait is reimbursed at 50% of the standard vocational counselor rate, regardless of referral type or provider specialty. Travel/wait must be pro-rated if more than one referral is included in a particular trip.

Mileage, as determined by the federal rate, is reimbursed at the same rate as that of travel on state business. The department reimburses mileage at the same rate, regardless of referral type or provider specialty.

For More Information
The **Internet address** where information is available is as follows:

http://www.lni.wa.gov/rules/

Obtaining a Copy of the Vocational Rehabilitation Rules
Providers can obtain a copy of the rules governing vocational services (WAC 296-19A) through the Internet at the following address:

http://www.lni.wa.gov/rules/voc%20rehab/vocrehabcr103.htm

COMPLETING THE "STATEMENT FOR MISCELLANEOUS SERVICES" FORM

The Department of Labor and Industries and service providers are joined in a cooperative process for payment of provider billings. In order to process the billings in a timely manner, the billings must be completed as described. Improperly completed bill forms may be returned to the provider for completion/correction and resubmission.

Completed bill forms MUST be typed or printed and be clearly legible. Bills must be submitted on ORIGINAL (not photocopies or facsimiles) Statement for Miscellaneous Services forms. All boxes on the form other than those identified, as "not applicable" MUST be completed to ensure correct bill adjudication.

DO NOT STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

All boxes on the form other than those identified, as "not applicable" **must** be completed in order to ensure correct bill adjudication.

1. Check the box indicating the applicable category of service. If your particular service category is not listed, check the "OTHER" box (e.g., interpreter services and licensed massage therapists would check the "other" box).

2. **WORKER'S NAME:** Enter worker's last name, first name and middle name or initial.

3. **SOCIAL SECURITY NUMBER:** Enter worker's social security number. This information will assist us in identifying the injured worker's claim number if the claim number is missing or invalid.

4. **CLAIM NUMBER:** Enter the department-assigned claim number for the injury/condition being treated. Omission of this number will result in denial of payment.

   Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source, which is listed below.

STATE FUND INDUSTRIAL INSURANCE	Claim numbers are six digits, preceded by the letter "B, C, F, G, H, J, K, L, M, N, P, X or Y". Effective 1/1/2000, Department of Energy (DOE) claims are administered by Self-Insurance. All other DOE claims previous to 1/1/2000, are administered by the State Fund. DOE claims have seven digits with no preceding letter.

Send bills for State Fund claims to

Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

CRIME VICTIMS	Crime Victims' Compensation Program claim numbers are either six digits preceded by a "V," or five digits preceded by a "VA, VB, VC, VH or VJ".

Send Bills for Crime Victims claims to

Department of Labor and Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

SELF-INSURANCE	Self-Insurance claim numbers are six digits preceded by an "S, T or W." Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

5. **ADDRESS:** Enter worker's current address.

6. **EMPLOYER'S NAME:** Enter worker's employer's name.

* **REIMBURSE INJ WORKER:** Check applicable box indicating whether the injured worker has paid for the services.

7. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and **must** be included. A worker may have several claims; therefore, it is vital that the proper claim be identified and charged for services provided.

8. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter name of the doctor referring claimant to you, if applicable.

9. **REFERRING PHYSICIAN PROVIDER NUMBER:** Enter L&I provider account number of referring doctor.

10. **DIAGNOSIS:** ICD9-CM code is not required. However, you must provide a narrative description, e.g., broken glasses, left eye injury, left leg injury, etc. **Designate left or right side of body, when applicable.**

11. **FOR GLASSES:** Indicate "yes" or "no," if applicable to service being provided.

12. **SERVICES RELATED TO HOSPITALIZATION:** Not applicable.

13. **ITEMIZATION OF SERVICES AND CHARGES:**
    A. **DATE OF SERVICE:** Record one date of service per line.

    B. **PLACE OF SERVICE:** Enter required 2-digit place of service code. See list of codes in the *Place of Service* section of this booklet or on the reverse side of the bill form.

    C. **TYPE OF SERVICE:** Enter appropriate type of service code. See list of codes on the last page of this booklet or on the reverse side of the bill form.

D. **PROCEDURE CODE:** This code identifies the procedures performed or items provided (CPT/HCPCS/Local Code). The department's **Medical Aid Rules and Fee Schedules** lists the procedure code. Enter only one code per line.

E. **PROCEDURE CODE MODIFIER:** Use only if applicable to your provider type and service provided. Modifiers are listed in the RBRVS section of the current fee schedule.

F. **DESCRIBE PROCEDURES:** Enter brief description of services or supplies furnished.

G. **DENTAL TOOTH NUMBER:** Enter tooth number. (Dental Services use only)

H. **HOME NURSING:** Enter number of hours. (Home Nursing Services use only)

I. **GLASSES:** Complete this box as indicated. (Optometrist & Optician use only)

J. **CHARGES:** Total line item charge. (Do not bill negative charges.)

K. **UNIT:** Enter the total number of days, units, total hours, or miles for the services billed on a line: e.g., rental, lodging, multiple packages of supplies, transportation, etc.

14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

    Provider Accounts
    Department of Labor and Industries
    PO Box 44261
    Olympia WA 98504-4261
    Fax 360-902-4484

    PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) THAT YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.
    Indicating a new address on the bill will not change the department's record of your address and could delay payment.

15. **PROVIDER NUMBER:** Enter the L&I provider account number assigned by the department for the provider of service.

16. **TOTAL CHARGE:** Total of **all** charges for services provided.

17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number you use to identify your patient's account. This number is for your convenience only.

18. **BILL DATE:** The date your billing was prepared.

19. **REMARKS:** Enter any further information necessary to explain your charges.

20. **REFERRAL ID:** Enter appropriate referral identification number.

NO STAPLES IN BAR CODE AREA

[redacted]

STATEMENT FOR MISCELLANEOUS SERVICES

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☐ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

WORKER'S NAME IN FULL First Middle Last	Social Security Number (for ID only)	Claim Number
Address	Employer's Name	
City State ZIP	Reimburse Injured Worker ☐ Yes ☐ No	Amount Paid $
Date of Injury	Name of referring physician or other source	Referring physician provider number

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: Bill date: / /

Remarks:

Provider or Supplier name | Provider number | Total Charge

Address | Phone Number

City State ZIP + 4 | Your Patient's Account Number

Federal tax ID number ☐ EIN ☐ SSN

Referral ID

F245-072-000 statement for misc services 4 / 01 * Place of Service (POS) and Type of Service (TOS) codes on back

INSTRUCTIONS FOR COMPLETING MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
2. **CLAIM NUMBER: For the injured worker receiving services.**

INDUSTRIAL INSURANCE Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N, P, X or Y." Crime victim claim numbers are six digits preceded by a "V",

Send bills for Industrial Insurance claims to:
Department of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

Send bills for Crime Victims claims to:
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

SELF INSURANCE Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location. Self-insurance claim numbers are six digits preceded by an "S, T or W". Bills for all self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

3. **INJURED WORKER'S NAME:** Injured worker's full name, last name first.
4. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It helpful when the claim number is wrong and the worker's name is common.
5. **ADDRESS:** The injured worker's most current address.
6. **EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
7. **DATE OF INJURY:** This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
9. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Department of Labor and Industries provider account number of the referring physician. The number may be Obtained from the referring physician. (Not applicable for Vocational Services billing.)
10. **DIAGNOSIS:** Indicate both the ICD9-CM number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The Diagnosis presented must be specific. (Not applicable for Vocational Services billins.)
11. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
13. **ITEMIZATION OF SERVICES AND CHARGES:**
    - **A. DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
    - **B. PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
    - **C. TYPE OF SERVICE:** A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
    - **D. PROCEDURE CODE:** Identifies the procedure used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
    - **E. CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
    - **F. DENTAL:** To be used for dental services only.
      Tooth Number: Identify dental services provided by placing the specific tooth number in the appropriate box.
    - **G. HOME NURSING:** To be used for home care only.
      Number of Hours or Day: Identify the number of hours or the number of days that the home care services were provided.
      Hourly or Daily Rate: Record the rate charged (by the hour or day) for the home care services provided.
    - **H. GLASSES:** To be used for glasses repair or replacement only.
      Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.
      New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
    - **I. CHARGES:** Charges for services provided.
    - **J. UNIT:** The sum total services provided for days, units, or miles, etc.
14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.
15. **PROVIDER NUMBER:** Identification number designated by the Department of Labor and Industries for the provider.
16. **TOTAL CHARGE:** Total of **all** charges for services provided.
17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's explanation.
18. **REMARKS:** Any information necessary that the provider or supplier feels is necessary for further explanation.

ATTACHMENTS

The following attachments **must be** submitted with billings for appropriate services:

1. X-ray findings
2. Lab reports
3. Office notes
4. Operative reports
5. Emergency Room reports
6. Diagnostic Study reports
7. Cost invoice of supplies furnished
8. Consultaton reports

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.
The following attachment is not acceptable: Office Visit Slips.

REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill; **same** charges, codes and billing dates. Please indicate **"Rebill"** on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

PLACE OF SERVICE (POS)

1. Inpatient Hospital
2. Outpatient Hospital
3. Office
4. Residence
5. Emergency Room
6. Other Medical/Surgical Facilities
7. Nursing Home
8. Other Location

TYPE OF SERVICE (TOS)

C Chiropractic Services
D Drugless Therapeutics
I Inpatient
N Nurse Practitioner Services
O Outpatient
P Physical Therapy
V Vocational Services
3 Medical Services
4 Dental
9 Ancillary Services (attendant, equipment, glasses)

F245-072-000 statement for misc. services (backer) 4/01

NO STAPLES IN BAR CODE AREA

[redacted]

STATEMENT FOR MISCELLANEOUS SERVICES

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE ARNP

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker Yes No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD X	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? Yes No ☐

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services. ☐	Dental Tooth Number ☐	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
3/1/01	xx	N	xxxxx								xx.xx	X	3/1/01

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX ARNP	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX EIN SSN		
		Refferal ID

Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

F245-072-000 statement for misc services 4/01

* Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE CRNA

WORKER'S NAME IN FULL (Last / First / Middle)	Social Security Number (for ID only)	Claim Number
Doe / John / A	123-45-6789	Y 000000
Address	**Employer's Name**	
123 E 5th Ave	ABC Employer	
City / State / ZIP	**Reimburse Injured Worker**	**Amount Paid $**
Any City / WA / 98512	☐ Yes ☒ No	
Date of Injury	**Name of referring physician or other source**	**Referring physician provider number**
XX-XX-XX	XXXXX XXXXXXXX MD	XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	N	xxxxx								xx.xx	X	3/1/01

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: VVVVVVVVVV

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX CRNA	xxxxxxx	$ XX.XX
Address		**Phone Number**
123 E 5th Ave		(XXX) XXX-XXXX
City / State / ZIP + 4		**Your Patient's Account Number**
Any City / WA 00000-0000		XXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01

* Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE RNFA

WORKER'S NAME IN FULL (Last / First / Middle)	Social Security Number (for ID only)	Claim Number
Doe / John / A	123-45-6789	Y 000000
Address	**Employer's Name**	
123 E 5th Ave	ABC Employer	
City / State / ZIP	**Reimburse Injured Worker**	**Amount Paid $**
Any City / WA / 98512	☐ Yes ☒ No	
Date of Injury	**Name of referring physician or other source**	**Referring physician provider number**
XX-XX-XX	XXXXX XXXXXXXX MD	XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	N	xxxxx								xx.xx	X	3/1/01

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: VVVVVVVVVV

Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX RNFA	xxxxxxx	$ XX.XX
Address		**Phone Number**
123 E 5th Ave		(XXX) XXX-XXXX
City / State / ZIP + 4		**Your Patient's Account Number**
Any City / WA 00000-0000		XXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01

* Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- [X] Dental Services
- [ ] Glasses
- [ ] Medical Equipment/ Prosthetics-Orthotics
- [ ] Vocational/ Retraining
- [ ] Transportation
- [ ] Other
- [ ] Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

WORKER'S NAME IN FULL Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe / John / A	123-45-6789	Y 000000
Address	**Employer's Name**	
123 E 5th Ave	ABC Employer	
City / State / ZIP	**Reimburse Injured Worker**	**Amount Paid $**
Any City / WA / 98512	[ ] Yes [X] No	
Date of Injury	**Name of referring physician or other source**	**Referring physician provider number**
XX-XX-XX	XXXXX XXXXXXXX MD	XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? [ ] Yes [ ] No

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	4	D0120		Exam						xx.xx	X	3/1/01
3/1/01	xx	4	D0330		Panoramic Film						xx.xx	X	3/1/01
3/1/01	xx	4	D7110		Tooth Extraction Including anesth local	9					xx.xx	X	3/1/01

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX DDS	xxxxxxx	$ XX.XX
Address		**Phone Number**
123 E 5th Ave		(XXX) XXX-XXXX
City / State / ZIP + 4		**Your Patient's Account Number**
Any City / WA 00000-0000		XXXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX [ ] EIN [ ] SSN		**Referral ID**

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

DO NOT WRITE IN SPACE >

SAMPLE DME

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☒ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☐ Other
- ☐ Home Health/ Nursing Home Services

WORKER'S NAME IN FULL Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe / John / A	123-45-6789	Y 000000
Address	**Employer's Name**	
123 E 5th Ave	ABC Employer	
City / State / ZIP	**Reimburse Injured Worker**	**Amount Paid $**
Any City / WA / 98512	☐ Yes ☒ No	
Date of Injury	**Name of referring physician or other source**	**Referring physician provider number**
XX-XX-XX	XXXXX XXXXXXXX MD	XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.

1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	9	E0105	XX	Cane – 3 pronged rental						xx.xx	X	3/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX	xxxxxxx	$ XX.XX
Address		**Phone Number**
123 E 5th Ave		(XXX) XXX-XXXX
City / State / ZIP + 4		**Your Patient's Account Number**
Any City / WA 00000-0000		XXXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE DRUG & ALCOHOL

WORKER'S NAME IN FULL — Last / First / Middle	Social Security Number (for ID only)	Claim Number
Doe / John / A	123-45-6789	Y 000000
Address	**Employer's Name**	
123 E 5th Ave	ABC Employer	
City / State / ZIP	**Reimburse Injured Worker**	**Amount Paid $**
Any City / WA / 98512	☐ Yes ☒ No	
Date of Injury	**Name of referring physician or other source**	**Referring physician provider number**
XX-XX-XX	XXXXX XXXXXXXX MD	XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1. XXX.XX
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	9	0141M		Intake Eval						xx.xx	X	3/1/01
3/1/01	xx	9	0143M		Individual Therapy						xx.xx	X	3/1/01
3/1/01	xx	9	0143M		Detox Facility			xx.xx			xx.xx	X	3/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX	xxxxxxx	$ XX.XX
Address		**Phone Number**
123 E 5th Ave		(XXX) XXX-XXXX
City / State / ZIP + 4		**Your Patient's Account Number**
Any City / WA 00000-0000		XXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE LMT

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	9	97124		Massage – 1 hour						xx.xx	4	3/1/01
3/5/01	xx	9	97124		Massage – 1 hour						xx.xx	4	3/5/01
3/7/01	xx	9	97124		Massage – 1 hour						xx.xx	4	3/7/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX LMT	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE NURSE CASE MGMT

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
3/1/01	xx	9	1220M		Phone Calls						xx.xx	X	4/1/01
3/1/01	xx	9	1221M		Visits						xx.xx	X	4/1/01
3/1/01	xx	9	1222M		Case Planning						xx.xx	X	4/1/01
3/1/01	xx	9	1223M		Travel / Wait						xx.xx	X	4/1/01
3/1/01	xx	9	1224M		Mileage						xx.xx Total Miles ↗	X	4/1/01
3/1/01	xx	9	1225M		Expenses						xx.xx	X	4/1/01

CPT codes and descriptions are © 2000 American Medical Association

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX NCM	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01

* Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Glasses
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Vocational/ Retraining
- ☐ Transportation
- ☒ Other
- ☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE OBESITY TREATMENT

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	X	1030M		Intake Dietary Evaluation						xx.xx	X	3/1/01
3/1/01	xx	X	1034M		Dietary Evaluation						xx.xx	X	3/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: WA 00000-0000		Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		Referral ID

F245-072-000 statement for misc services 4/01

* Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

☐ Dental Services ☐ Glasses
☐ Medical Equipment/ Prosthetics-Orthotics ☐ Vocational/ Retraining
☐ Transportation ☒ Other
☐ Home Health/ Nursing Home Services

DO NOT WRITE IN SPACE >

SAMPLE OCCUPATIONAL THERAPY

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
(use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	9	97003		Occupational Therapy Eval						xx.xx	X	3/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name: XXXXX XXX OT
Provider number: xxxxxxx
Total Charge: $ XX.XX

Address: 123 E 5th Ave
Phone Number: (XXX) XXX-XXXX

City: Any City State: WA ZIP + 4: 00000-0000
Your Patient's Account Number: XXXXXXXXXXXX

Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN

Referral ID

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☐ Vocational/ Retraining
- ☒ Other

DO NOT WRITE IN SPACE > SAMPLE OPTICIAN

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services
Admitted _____/_____/_____
Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	9	V2020		Frames – Purchase						xx.xx	1	3/1/01
3/1/01	xx	9	V2100		Sphere Single Vision						xx.xx	2	3/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
XXXXX XXX	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX ☐ EIN ☐ SSN		
		Referral ID

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☒ Vocational/ Retraining
- ☐ Other

DO NOT WRITE IN SPACE >

SAMPLE VOCATIONAL REBAB SERVICES

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
6/1/01	xx	V	0800V		Early Intervention Svc						xx.xx	X	6/1/01
6/1/01	xx	V	0810V		Assessment Services						xx.xx	X	6/1/01
6/1/01	xx	V	0830V		Plan Development Svcs						xx.xx	X	6/1/01
6/1/01	xx	V	0840V		Plan Implementation Svc						xx.xx	X	6/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

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Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
Voc Rehab Counselor	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☐ EIN ☐ SSN		Referral ID: XXXXXXXXXX

F245-072-000 statement for misc services 4/01

* Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☒ Vocational/ Retraining
- ☐ Other

DO NOT WRITE IN SPACE >

SAMPLE VOCATIONAL REBAB SERVICES

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing: No of hrs/day	Home Nursing: Hourly Day rate	Glasses: OLD RX OD OS	Glasses: NEW RX OD OS	Charges $	Unit	TO DATE OF SERVICE
6/1/01	xx	V	0801V		Early Intervention Svc - Intern						xx.xx	X	6/1/01
6/1/01	xx	V	0811V		Assessment Services – Intern						xx.xx	X	6/1/01
6/1/01	xx	V	0824V		Pre-job or Job Modification Consultation - Intern						xx.xx	X	6/1/01
6/1/01	xx	V	0841V		Plan Implementation Services - Intern						xx.xx	X	6/1/01
					CPT codes and descriptions are © 2000 American Medical Association								

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
Voc Rehab Intern	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☐ EIN ☐ SSN		Referral ID: XXXXXXXXXX

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

STATEMENT FOR MISCELLANEOUS SERVICES

NO STAPLES IN BAR CODE AREA

[redacted]

Dept of Labor and Industries
PO Box 44267
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/ Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/ Nursing Home Services
- ☐ Glasses
- ☒ Vocational/ Retraining
- ☐ Other

DO NOT WRITE IN SPACE > SAMPLE VOCATIONAL REBAB SERVICES

WORKER'S NAME IN FULL First Middle	Social Security Number (for ID only)	Claim Number
Last Doe John A	123-45-6789	Y 000000
Address: 123 E 5th Ave	Employer's Name: ABC Employer	
City: Any City State: WA ZIP: 98512	Reimburse Injured Worker ☐ Yes ☒ No	Amount Paid $
Date of Injury: XX-XX-XX	Name of referring physician or other source: XXXXX XXXXXXXX MD	Referring physician provider number: XXXXXXX

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.
1.
2.
3.
4.
5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted _____/_____/_____

Discharged _____/_____/_____

REFUND CERTIFICATION
I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

FROM DATE OF SERVICE	POS	TOS	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges $	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
6/1/01	xx	V	0881V		Vocational Expert Svcs						xx.xx	X	6/1/01
6/1/01	xx	V	0895V		Air Travel						xx.xx	X	6/1/01

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: VVVVVVVVVV Bill date: MM / DD / YY

Remarks:

Provider or Supplier name	Provider number	Total Charge
Voc Rehab Councelor Forensic	xxxxxxx	$ XX.XX
Address: 123 E 5th Ave		Phone Number: (XXX) XXX-XXXX
City: Any City State: WA ZIP + 4: 00000-0000		Your Patient's Account Number: XXXXXXXXXXXX
Federal tax ID number: XX-XXXXXXX ☐ EIN ☐ SSN		Referral ID: XXXXXXXXXX

F245-072-000 statement for misc services 4/01 * Place of Service (POS) and Type of Service (TOS) codes on back

REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.
Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice

You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be received at the department **within one year of the date the final order was issued** which reopened or allowed the claim or diagnosis.

A Rebill should be identical to the original bill: same charges, codes and dates of service.
Rebills should be submitted on new ORIGINAL bill forms. We cannot process photocopies or facsimiles.

ADJUSTMENTS

A "Providers Request for Adjustment " form (F245-183-000) should be submitted to correct an incorrect field on a bill that has **already processed and partially paid**.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers name and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

					Service Dates				Billed
Claim #	Name	I	Patient Acct#	ICN	From	To	Unit	Procedure	Charge
P000000	XXXXXXX	X	XXXXXXXXXX	**09936425045000200**	121399	121799	1	XXXXX	XX.XX

In the body of the form (field 8) correct only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information (as it should have appeared on the original bill) in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

EXAMPLE:

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on **adjustments initiated by the department**

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a payment must be made in writing within 20 days of receipt of notice of the adjustment/deduction.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments fee schedule.

All supporting documentation relevant to the reconsideration request must be submitted with the request.

Note:
DO NOT SUBMIT an adjustment or a rebill for a bill that is reported "in process" on your Remittance Advice. If the bill remains in the "in process" status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills "in process" **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the 'in process' bill information, you may choose the 'zero' option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on page 38)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., $100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., $125.00). The difference between original and adjusted payment will be paid in the warrant (e.g., $25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., $100.00).

If the original payment is being recouped, the total or partial amount allowed for the bill will be reported (e.g., $0.00). The "adjusted payment" will recoup the original amount of the bill and report the difference as a credit, CRE **(monies owed back to the department).**

NO STAPLES IN
BAR CODE AREA

Department of Labor and Industries
Claims Section
PO Box 44267
Olympia WA 98504-4267

PROVIDER'S REQUEST FOR ADJUSTMENT

CHECK→ ONE

- ☐ TOTAL OVERPAYMENT
- ☐ PARTIAL OVERPAYMENT
- ☐ UNDERPAYMENT

DO NOT WRITE IN SPACE

Please type or print in dark ink

ENTER DATA FROM ORIGINAL REMMITTANCE ADVICE	**INSTRUCTIONS ARE ENCLOSED**	
1) WORKERS NAME (Last, First, Middle)	2) CLAIM NUMBER ON REMIT ADVICE	3) CORRECT CLAIM NUMBER
4) PROVIDER NAME AND ADDRESS	5) ICN NUMBER ON REMITTANCE ADVICE	
	6) PROVIDER NUMBER	
	7) PAYEE NUMBER	

COMPLETE ONLY THOSE LINE ITEMS PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION

8) Line Item #	a) From/to Date of Service or Covered Dates	b) POS	c) TOS	d) Procedure Code/ Revenue Code/NDC	e) CODE MOD	f) ICD-9-CM Diagnosis/ Side of Body	g) Tooth Number	h) Charge	i) Days/ Units/ Quantity	j) Days Supply	k) Description
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											

9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER
		( )

F245-183-000 provider's request for adjustment 2/00

SAMPLE PAGE
BLMC8000-R001
AS OF 03/28/2001

DEPARTMENT OF LABOR AND INDUSTRIES
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME
PROVIDER'S STREET ADDRESS
CITY, STATE ZIP

PAYEE PROVIDER NUMBER **0000000** REMIT ADVICE # **XXXXXX** WARRANT REGISTER NUMBER **60048** DATE **03/30/2001** PAGE **X**

CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON-COVD CHARGES	PAYABLE	EOB CODES
PAID BILLS - MISCELLANEOUS BILL													
Y000000	XXXXXXX	X	XXXXXXXXXX	00111525045000200	011301	011701	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					011301	011701	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					011301	011701	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					011301	011701	1	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					BILL TOTAL***				XX.XX	XX.XX	0.00	XX.XX	
***PAID BILLS TOTAL – MISCELLANEOUS BILLS					**NUMBER OF BILLS			1	XX.XX	XX.XX	0.00	XX.XX	
BILLS-IN-PROCESS - MISCELLANEOUS BILL													
X000000	XXXXXXX	X	XXXXXXXXXX	00111525030003700	012201	012201	1	XXXXX	X.XX	X.XX	0.00	X.XX	
					012201	012201	2	XXXXX	XX.XX	XX.XX	0.00	XX.XX	
					BILL TOTAL **				XX.XX	XX.XX	0.00	XX.XX	559
***BILLS PENDING TOTAL – MISCELLANEOUS BILLS					***NUMBER OF BILLS-			1	XX.XX	0.00	0.00	0.00	
DENIED BILLS – PRACTITIONER BILL													
X000000	**XXXXXXX**	**X**	**321**	**00111525004006000**	**012101**	**012501**	**1**	**##M##**	**XX.XX**	**0.00**	**0.00**	**0.00**	**045**
					012101	**012501**	**1**	**###A#**	**XXX.XX**	**0.00**	**0.00**	**0.00**	**045**
					012101	**012501**	**1**	**M####**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
					BILL TOTAL**				XXX.XX	XXX.XX	0.00	XXX.XX	
***DENIED BILL TOTAL – MISCELLANEOUS BILLS					***NUMBER OF BILLS-			1	XXX.XX	XXX.XX	0.00	XXX.XX	
ADJUSTMENT – BILLS - MISCELLANEOUS BILL													
X000000	**XXXXXXX**	**X**	**321**	**00111725007101500**	**012101**	**012501**	**1**	**##M##**	**XX.XX-**	**0.00-**	**0.00**	**0.00-**	
					012101	**012501**	**1**	**###A#**	**XXX.XX-**	**0.00-**	**0.00**	**0.00-**	
					012101	**012501**	**1**	**M####**	**XXX.XX-**	**XXX.XX-**	**0.00**	**XXX.XX-**	
					BILL TOTAL**				XXX.XX-	XXX.XX-	0.00	XXX.XX-	CRE
X000000	**XXXXXXX**	**X**	**321**	**00111725007201500**	**012101**	**012501**	**1**	**M####**	**XX.XX**	**XX.XX**	**0.00**	**XX.XX**	
					012101	**012501**	**1**	**A####**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
					012101	**012501**	**1**	**M####**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	
					BILL TOTAL**				XXX.XX	XXX.XX	0.00	XXX.XX	
****ADJUSTMENT TOTALS – MISCELLANEOUS BILL**					****NUMBER OF BILLS -**			**2**	**XXX.XX**	**XXX.XX**	**0.00**	**XXX.XX**	

EOB 045 – Denied. Type Service/Procedure Code is invalid. Refer to current Fee Schedule for valid code.

TYPE OF SERVICE CODES:

C	Chiropractic Services	P	Physical Therapy
D	Drugless Therapeutics	V	Vocational Services
I	Inpatient	3	Medical Services
N	Nurse Practitioner Services	4	Dental
O	Outpatient	9	AncillaryServices (attendant,equipment, glasses)

PLACE OF SERVICE CODES:

11. Office
12. Patient's Home
21. Inpatient Hospital
22. Outpatient Hospital
23. Emergency Rm – Hospital
24. Ambulatory Surgical Ctr
25. Birthing Ctr
26. Military Trmt Facility
31. Skilled Nursing Facility
32. Nursing Facility
33. Custodial Care Facility
34. Hospice
41. Ambulance – Land
42. Ambulance – Air or Water
50. Federally Qualified Hlth Ctr
51. Inpatient Psychiatric Facility
52. Psychiatric Facility Partial Hospitalization
53. Community Mental Health Ctr
54. Intermediate Care Facility/Mentally Retarded
55. Residential Substance Abuse Trmt Facility
56. Psychiatric Residential Trmt Ctr
60. Mass Immunization Ctr
61. Comprehensive Inpatient Rehabilitation Facility
62. Comprehensive Outpatient Rehab Facility
65. End Stage Renal Disease Trmt Facility
71. State or Local Public Health Clinic
72. Rural Hlth Clinic
81. Independent Laboratory
99. Other Unlisted Facility

Directory:
FIELD SERVICE OFFICES

Aberdeen:
415 West Wishkah, Suite 1B
Aberdeen WA 98520-0013
(360) 533-8200

Bellevue:
616 120th Avenue NE, Suite C201
Bellevue WA 98005-3037
(425) 990-1400

Bellingham:
1720 Ellis Street, Suite 200
Bellingham WA 98225-4600
(360) 647-7300

Bremerton:
500 Pacific Avenue, Suite 400
Bremerton WA 98337-1904
(360) 415-4000

Colville:
298 South Main, Suite 203
Colville WA 99114-2416
(509) 684-7417
1-800-509-9174

East Wenatchee:
519 Grant Road
East Wenatchee WA 98802-5459
(509) 886-6500
1-800-292-5920

Everett:
729 100th St SE
Everett WA 98208-3727
(425) 290-1300

Kennewick:
500 N Morain, Suite 1110
Kennewick WA 99336-2683
(509) 735-0100
1-800-547-9411

Longview:
900 Ocean Beach Hwy
Longview WA 98632-4013
(360) 575-6900

Moses Lake:
3001 W Broadway Ave
Moses Lake WA 98837-2907
(509) 764-6900

Mount Vernon:
525 E College Way, Suite H
Mount Vernon WA 98273-5500
(360) 416-3000

Okanogan:
1234 2nd Avenue S
Okanogan WA 98840-0632
(509) 826-7345

Port Angeles:
1605 East Front Street, Suite C
Port Angeles WA 98362-4628
(360) 417-2700

Pullman:
1250 Bishop Blvd SE, Suite G
PO Box 847
Pullman WA 99163-0847
(509) 334-5296
1-800-509-0025

Seattle:
300 W Harrison Street
Seattle WA 98119-4081
(206) 281-5400

Spokane:
901 N Monroe Street, Suite 100
Spokane WA 99201-2149
(509) 324-2600
1-800-509-8847

Tacoma:
950 Broadway Suite 200
Tacoma WA 98402-4453
(253) 596-3800

Tukwila:
12806 Gateway Drive
PO Box 69050
Seattle WA 98168-1050
(206) 248-8240

Tumwater:
PO Box 44851
7273 Linderson Way SW
Olympia WA 98504-4851
(360) 902-5799

Vancouver:
312 SE Stonemill Dr, Suite 120
Vancouver WA 98684-3508
(360) 896-2300

Walla Walla:
1815 Portland Avenue, Suite 2
Walla Walla WA 99362-2246
(509) 527-4437

Yakima:
15 W Yakima Avenue, Suite 100
Yakima WA 98902-3480
(509) 454-3700
1-800-354-5423

*** indicates Regional Office**
(Revised 4/11/2001)